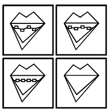

WELCOME TO OUR OFFICE!

Please fill in the appropriate information

Date: ____________________

Name: ____________________ **Nickname:** ____________________
Address: ____________________ Home Phone: ____________________
City, State, Zip: ____________________ Birthdate: ____________________
Age: __________ Sex: __________

School: ____________________ Grade: ______ Musical Instrument? ____________________
Special Interests or Hobbies: ____________________
E-Mail address (for confirmation of appointments) ____________________

Father's or Guardian's Name: ____________________ Relationship to Patient: ____________________
Home Address: ____________________ Home Phone: ____________________
Employed by: ____________________ Business Phone: ____________________
Occupation: ____________________ SS# ____________________ Cell Phone: ____________________

Mother's or Guardian's Name: ____________________ Relationship to Patient: ____________________
Home Address: ____________________ Home Phone: ____________________
Employed by: ____________________ Business Phone: ____________________
Occupation: ____________________ SS# ____________________ Cell Phone: ____________________

Siblings (give names and dates of birth) ____________________

Who is financially responsible? ____________________ SS# ____________________
(if different than above information)

Marital Status of Responsible Party: Single Married Widowed Separated Divorced

Do you have Dental / Orthodontic insurance? Yes No
If yes, please complete the insurance information form to assist in the verification benefits.
Do you use a Reimbursement Account? Yes No (Flex Plan, Cafeteria Plan)

Patient's General Dentist: ____________________ **Dentist's Phone:** ____________________
Patient's Physician: ____________________ Physician's Phone: ____________________
Whom may we thank for referring you? ____________________
Relatives treated here: ____________________
Has there been any previous orthodontic consultation or treatment? ____________________
Chief reason treatment is being sought? ____________________

DENTAL HISTORY	Yes	No
Has patient ever sucked his or her thumb or fingers?		
Does patient breathe through the mouth more than through the nose		
Have you been informed of any missing permanent teeth?		
Have you been informed of any extra teeth?		
Have any teeth been injured due to accidents or falls?		
Has the patient had any severe head or facial injuries?		
Is the patient especially apprehensive toward dental visits?		
Does the patient have a history of pain, clicking or popping of jaw joint?.		

MEDICAL HISTORY (√ check those which apply)

Heart trouble	Anemia	Frequent headaches
Kidney problems	Hepatitis	HIV positive or AIDS
Emotional problems.	Allergies	Asthma/hay fever
Rheumatic fever	Diabetes	Tonsils/adenoids removed.
Prolonged bleeding	Pregnant	Wear contact lenses
Fainting or dizziness.	Epilepsy	Frequent canker sores or or fever blister
Latex allergy		

NONE APPLY

Other serious illnesses (specify): ____________________

List any drugs or medications now being taken: ____________________

►I certify that the information provided on this form is correct to the best of my knowledge. I verify that I have legal custody of the above-named minor.

►I consent to the taking of diagnostic radiographs, photographs, and study models before, during and after treatment, and to the use of the same by the doctor in scientific papers or demonstrations.

► I authorize release of any information including diagnosis and record of any treatment of the above named patient to third party payors and/or health practitioners.

►I authorize and request my insurance company (if applicable) to pay directly to the office any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be financially responsible for payment of all services rendered on my behalf.

____________________ RESPONSIBLE PARTY (LEGAL GUARDIAN) ____________________ DATE